SPSO Scottish Public Services Ombudsman

The Scottish Public Services Ombudsman Act 2002

Investigation Report

UNDER SECTION 15(1)(a)

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Scottish Parliament Region: Lothian

Case 201301767: Lothian NHS Board

Summary of Investigation

Category

Health: Hospital; care of the elderly

Overview

The complainant (Mrs C) raised concerns that the standard of care and treatment provided to her late mother (Mrs A) from two hospitals following a fall was not reasonable and included concerns about communication, treatment decisions, discharge and provision of nutrition and fluids.

Specific complaints and conclusions

The complaints which have been investigated are that:

(a) the Western General's care and treatment of Mrs A in 2013 was unreasonable (*upheld*); and

(b) the Royal Infirmary of Edinburgh's care and treatment of Mrs A in 2013 was unreasonable (*upheld*).

Redress and recommendations

The Ombudsman recommends that Lothian NHS Board (the Board):	*Completion date*
(i) ensure that any recorded assessment of a patient is accurate and a reliable source on which to base the planning of care and supervision;	7 January 2015
(ii) ensure that the presence of cognitive impairment is given due regard in the planning of care, and that the level of observation, supervision and support provided to people with delirium and/or dementia is appropriate for their impaired capacity;	7 January 2015
(iii) take steps to ensure that communication with relatives or carers of patients with cognitive impairment is proactive and systematic;	7 January 2015
(iv) ensure the failures identified are raised with relevant staff;	7 January 2015

(v)	review their practice in relation to the pre-operative provision of nutrition and fluid in light of Nursing Adviser 2's comments;	7 January 2015
(vi)	ensure that clinical practice, decision-making processes and clinical records in relation to DNACPR decisions are in line with the relevant policy; and	7 January 2015
(vii)	apologise to Mrs C for the failures identified in this investigation.	7 January 2015

The Board have accepted the recommendations and will act on them accordingly.

Main Investigation Report

Introduction

1. Mrs A had a complex medical history and was admitted to the Western General Hospital on 14 March 2013 with pneumonia and associated confusion and hallucination. Later that evening (on 14 March 2013), Mrs A fell in the ward when going to the toilet and she sustained a fracture immediately above the knee. She was transferred to the Royal Infirmary of Edinburgh during the early hours of 15 March 2013 for planned surgery. The operation was undertaken on 20 March 2013. The following day (on 21 March 2013), Mrs A was transferred to an orthopaedic ward, and on 8 April 2013 transferred to another orthopaedic ward (at the Western General Hospital). She was discharged home on 1 May 2013. On 6 May 2013, Mrs A was admitted to the Royal Infirmary Edinburgh following concerns by healthcare professionals and her family that she was not coping at home and she was admitted to an orthopaedic ward on 7 May 2013. In the early morning of 8 May 2013, Mrs A became acutely and severely unwell and she passed away.

2. Mrs A's daughter (Mrs C) complained that the last seven weeks following Mrs A's fall on 14 March 2013 were horrific and that the fall and subsequent fracture led directly to her death, which would not have happened if the hospitals had acted properly. She was also concerned about the repeated fasting which happened when surgery was postponed prior to going ahead on 20 March 2013.

3. The complaints from Mrs C which I have investigated are that:

(a) the Western General's care and treatment of Mrs A in 2013 was unreasonable; and

(b) the Royal Infirmary of Edinburgh's care and treatment of Mrs A in 2013 was unreasonable.

4. Mrs C complained to Lothian NHS Board (the Board) on 7 June 2013. The Board responded on 15 July 2013. Mrs C was unhappy with their response and brought her complaint to us on 5 August 2013.

Investigation

5. During the course of the investigation of this complaint, my complaints reviewer obtained and examined a copy of Mrs A's clinical records and the Board's complaint file. She obtained independent advice on the clinical aspects

of the complaint from advisers who specialise in mental health (Nursing Adviser 1), nursing (Nursing Adviser 2) and care of the elderly (the Medical Adviser).

6. I have not included in this report every detail investigated but I am satisfied that no matter of significance has been overlooked. Mrs C and the Board were given an opportunity to comment on a draft of this report.

Clinical background

7. Mrs A had a complex medical history which included heart disease, hypertension (high blood pressure), osteoarthritis (a form of arthritis affecting the joints), breast cancer and liver disease. She also had probable early dementia. She was admitted to the Western General Hospital on 14 March 2013 with pneumonia and associated confusion and hallucination. It was also noted that she had chronic back pain and knee pain as a consequence of arthritis, but was independently mobile with the aid of a zimmer or walking stick. The medical notes recorded that at 21:00 (on 14 March 2013), Mrs A fell in the ward when going to the toilet. She sustained a distal femur fracture. She was transferred to the Royal Infirmary of Edinburgh during the early hours of 15 March 2013 for planned surgery.

8. On 20 March 2013, the operation went ahead and when it was completed, Mrs A was transferred to a high dependency unit. A 'do not actively resuscitate' (DNACPR) decision had been taken (at the high dependency unit) and the form stated that cardiopulmonary resuscitation was unlikely to be successful due to Mrs A being 'housebound, [and having] multiple comorbidities, severe aortic stenosis' (narrowing of a valve in the heart). A note in the medical records of the discussion held with Mrs A's son stated 'explained the DNAR in place due to significant co-morbidities'. It was recorded the following day (on 21 March 2013) that when Mrs C raised concerns about not being informed of the DNACPR decision before it was made the doctor 'explained that DNAR placed at yesterday evening and could not speak to them prior'. Staff then discussed the reasons for the DNACPR decision, and it was recorded that the family were reassured. It was also documented that Mrs A was consistently confused making pain assessment difficult, and she was transferred to an orthopaedic ward. Mrs C discussed the DNACPR decision with another doctor on 22 March 2013 and it was agreed that it would be reversed because of the good recovery Mrs A had made following surgery.

9. On 8 April 2013, Mrs A was transferred to an older people's orthopaedic rehabilitation ward at the Royal Victoria Building (of the Western General Hospital). It was recorded that Mrs A was a falls risk when she was transferred, and that she had capacity and understood advice in relation to safety precautions and the use of the call bell system. She was discharged home on 1 May 2013. At the time, it was noted in her medical records that she was independent in relation to managing daily living activities and was self-mobilising with the aid of a zimmer frame.

10. On 5 May 2013, Mrs A was referred to the Royal Infirmary Edinburgh by the care service because she was not coping at home due to pain. The medical records indicated that she was examined by a doctor and said that she was feeling 'well'. Following a discussion between the doctor and orthopaedics, she was discharged home that evening. On 6 May 2013, Mrs A was admitted to the Royal Infirmary Edinburgh following concerns by healthcare professionals and her family that she was not coping at home (she was complaining of on-going pain in her left leg and poor mobility) despite having a full package of care in place. She was admitted to an orthopaedic ward on 7 May 2013. In the early morning of 8 May 2013, Mrs A became acutely and severely unwell and despite resuscitation attempts she passed away. Causes of death were reported as heart and liver disease.

(a) The Western General's care and treatment of Mrs A in 2013 was unreasonable

11. Mrs C said she was told in the (late) evening of 14 March 2013 that Mrs A fell out of bed and fractured her leg, which she believed was as a result of the Board failing to act properly. She said that she was given inconsistent accounts of what happened about Mrs A's fall. After her operation at another hospital, Mrs A was returned to the Western General Hospital on 8 April 2013 for rehabilitation. She was discharged on 1 May 2013, which Mrs C felt was too early because Mrs A had poor mobility and could not manage herself at home despite the care package in place.

The Board's response

12. The Board said that Mrs A was admitted to the Western General Hospital on 14 March 2013 for increasing confusion and tiredness. In the afternoon, she was admitted to a ward for further investigations. At 20:20, it was noted that Mrs A was sleeping; however, at 21:00, she was heard shouting in the toilet/shower room. She was found on the floor of the toilet, lying on her back,

and the light was off. The doctor was immediately informed; Mrs A was examined, pain relief was administered and an x-ray was taken at 22:00. The doctor reviewed Mrs A again then and although she sustained a broken thigh bone, she was stable. At 22:30, Mrs C was informed of what happened and Mrs A was transferred to a ward at Royal Infirmary of Edinburgh. The Board said it was not helpful that the mechanism of Mrs A's fall was reported wrongly to both Mrs C and Royal Infirmary of Edinburgh staff. The Board confirmed that Mrs A did not fall out of bed and apologised for the incorrect information. The Board appreciated how upsetting the incident must have been and said it was fully investigated in accordance with the Board's reporting protocol and that Mrs C had received a copy of the investigation report.

13. Having made good progress with her rehabilitation and following her discharge on 1 May 2013, the Board were sorry to learn Mrs A required admission again. There were very clear pathways through the post-operative phases of the rehabilitation process after orthopaedic procedures with physiotherapists and occupational therapists working with the nursing and medical teams to ensure that patients are discharged safely. However, the aim was to get patients home as soon as possible because generally they improved more quickly there and were not exposed to the risk of hospital acquired infections. The Board were sorry that Mrs A required emergency admission on 6 May 2013 and that she passed away so suddenly.

Advice obtained

14. My complaints reviewer asked Nursing Adviser 1 if the Board's falls prevention was reasonable and if Mrs A's cognitive impairment was taken into account. Nursing Adviser 1 clarified that Mrs A fell once (on 14 March 2013) and sustained a fracture immediately above the knee but that much of the standardised documentation relating to the file in her medical records was headed 'fractured neck of femur' (hip) which could lead to confusion. Nursing Adviser 1 went on to say that a full falls risk assessment and care plan should be completed within 24 hours of admission according to the Board's falls prevention policy. In Mrs A's case, a brief assessment was carried out on the day of her admission. However, the assessment information was contradictory in relation to her mobility before the fall (on 14 March 2013). It was clear from the medical records that some adaptions had been made at home (handrails have been installed) and that Mrs A normally mobilised with the aid of a walking frame, walking stick or tripod. Nevertheless, it was recorded twice in her medical records that she did not usually use mobility aids which contradicted

other entries made on the same day. The medical records were also clear in showing that Mrs A had cognitive impairment on admission, and was confused and hallucinated. Impaired mobility and cognitive impairment would have combined to elevate the risk of a fall occurring, especially in light of Mrs A's frequent toileting needs. The falls prevention planning which took place was extremely brief and the interventions specified did not include any form of enhanced observation or supervision, or the movement of Mrs A to a more easily observed area. Nursing Adviser 1 said that the breakdown in written communication may have led to a lack of clarity among staff and an under-appreciation of Mrs A's falls risk. This resulted in a level of supervision being specified that fell below what was necessary in the circumstances - especially in light of Mrs A's cognitive impairment and recorded frequent toileting needs. This was contrary to Nursing and Midwifery Council standards that nursing staff 'have a duty to communicate fully and effectively with … colleagues, ensuring that they have all of the information they need about people in your care'.

15. In relation to communicating with the family, Nursing Adviser 1 said that the evidence from the medical records suggested there was some family involvement in the admission and initial assessment process, but that this had not been explicitly recorded. The standardised admission document templates did not prompt the recording of relative or carer views, or their participation. Mrs C was told about Mrs A's fall within an hour and a half of it happening, which was reasonable in the circumstances because it allowed the x-ray results to be communicated to Mrs C. However, the circumstances of the fall appeared to have been inaccurately reported in that Mrs C was told it had been a fall from a bed, and not a fall within the toilet area. The Board acknowledged this, and that the attitudes of some staff may have fallen below the standards expected of them.

16. Turning finally to Mrs A's discharge on 1 May 2013, Nursing Adviser 1 said that there were risks associated with Mrs A's discharge home. She had a complex medical history and recent history of not coping at home. Her self-care abilities continued to be limited by pain, fatigue and a degree of lack of volition. However, the evidence from the medical records showed that the discharge was clearly a planned process initiated over a period of time. Mrs A had been assessed thoroughly and repeatedly by the multi-disciplinary team before going home and a package of care was put in place to help address the limitations in self-care. Nursing Adviser 1 said there was no sense that her discharge was impulsive or carried out to free up a bed. Nursing Adviser 1 concluded that

although the discharge failed, this did not mean that there was a failure in care and treatment and the decision to allow Mrs A to go home rather than be referred for further in-patient rehabilitation was reasonable.

(a) Conclusion

17. Mrs C complained that the Board failed to provide a reasonable standard of care and treatment to Mrs A when she was a patient at the Western General. In reaching my decision, I have taken into account Mrs A's clinical records and the advice I have received. The advice I have accepted is that the staff failed to assess Mrs A's mobility in a cohesive and reasonable way, and failed to take appropriate cognisance of her cognitive impairment in a falls risk context during her admission to the Western General. As a result, the actions put in place to minimise the risk of a fall occurring were not reasonable and fell below the standards expected within the Board's falls prevention policy. This led to a significant personal injustice to Mrs A in that while it was not possible to eliminate the risks of falling altogether, reasonable and appropriate falls management would have minimised the risks. Clearly, Mrs C and the family have also been extremely distressed by what happened, which was exacerbated by the shortcomings in communication. In relation to the discharge on 1 May 2013, Nursing Adviser 1 said this was reasonable. I accept that advice. However, in light of the significant failings in relation to record-keeping, falls prevention and communication, I uphold the complaint. I make a number of recommendations to address the failures identified.

(a) Recommendations

18. I recommend that the Board:	*Completion date*
(i) ensure that any recorded assessment of a patient is accurate and a reliable source on which to base the planning of care and supervision;	7 January 2015
(ii) ensure that the presence of cognitive impairment is given due regard in the planning of care, and that the level of observation, supervision and support provided to people with delirium and/or dementia is appropriate for their impaired capacity;	7 January 2015
(iii) take steps to ensure that communication with relatives or carers of patients with cognitive impairment is proactive and systematic; and	7 January 2015
(iv) ensure the failures identified are raised with	7 January 2015

relevant staff.

(b) The Royal Infirmary of Edinburgh's care and treatment of Mrs A in 2013 was unreasonable

19. Mrs C was concerned about the repeated postponement of Mrs A's operation (it had originally been scheduled for 16 March 2013 but did not take place until 20 March 2013), which meant that she fasted for a number of days and became very weak. The family asked staff for information but said that they got the impression that they were a bother. Mrs C also said that the day before the operation (on 19 March 2013), Mrs C attended the ward to be told that Mrs A had been found screaming in agony in the toilet where she had fallen. Mrs C said the doctor told her that Mrs A had fractured her leg in a different place to that reported by the Western General Hospital and that the operation would be difficult because of the spiral break on the bone and her heart condition. Mrs C was also concerned about communication by nursing staff in relation to Mrs A's operation (on 20 March 2013) and that Mrs C was wrongly told Mrs A had hip damage. Finally, in relation to the DNACPR decision, Mrs C said that staff unreasonably failed to involve the family in the decision-making.

The Board's response

20. The Board said that on 15 March 2013 Mrs A was admitted to a ward (at Royal Infirmary of Edinburgh) and placed in traction because of the leg fracture, and put on the list for theatre. The following day (16 March 2013) a staff nurse updated the family during visiting time. On 17 March 2013, Mrs A was placed fourth on the theatre list and fasted but this was cancelled at 15:00 due to lack of theatre time. Fasting ceased at this time and she had received intravenous fluids during the fasting to ensure she did not become dehydrated. The Board apologised for any distress caused by communication with staff and that feedback had been given to staff.

21. The Board said it was most regrettable that Mrs A's operation had to be cancelled on 18 March 2013 due to a patient requiring emergency treatment. Theatre was cancelled on 19 March 2013 for the same reason and the Board apologised for the distress caused. On 20 March 2013, Mrs A fasted again for theatre having been placed first on the list. She was reviewed by the anaesthetist beforehand. The Board confirmed that it was regularly anaesthetists who discussed the resuscitating status with the patient or relatives pre-operatively and they carried out resuscitation if it was required during operation. The Board were sorry that the family were not told about the high

dependency care in advance of the operation and said this was a precautionary measure. The Board also apologised that the family were given misinformation about Mrs A having hip damage. The senior charge nurse said that Mrs A received a high standard of care during her admission and staff cared for her appropriately.

Advice obtained

22. My complaints reviewer asked Nursing Adviser 2 if the provision of nutrition and fluid in the lead up to Mrs A's operation on 20 March 2013 was reasonable. In response, Nursing Adviser 2 said that the nursing notes in the period from admission to the Royal Infirmary of Edinburgh and surgery on 20 March 2013 were very sparse and seemed to entail Mrs A waiting for surgery. This was problematic for any patient due to the anxiety of waiting for a major operation but even more so in this case due to the pain that Mrs A was suffering. In addition, Mrs A was starved of food for 36 hours and while she had an intravenous infusion for this period, the delay of this length was unreasonable. Nursing Adviser 2 also referred to guidelines[1] that suggested patients were only required to fast for six hours prior to surgery, so the practice of fasting from midnight was not required in many cases and this 'catch all' approach was based on antiquated practice. Nursing Adviser 2 said that individual care planning should be in place to encourage theatre lists to be planned and allow patients to eat and drink for the period before their surgery is planned. It appeared that the individual care of Mrs A was lacking and, therefore, unreasonable. Nursing Adviser 2 concluded that she was critical of the pre-operative care given to Mrs A.

23. In relation to communication, Nursing Adviser 1 said that having considered the clinical records the evidence revealed communication with the family that was sporadic, unplanned and inconsistent and ineffectively recorded. Much of the communication had been prompted the family. For example, the medical records showed that Mrs A's family were updated in relation to the surgery being postponed on 16, 17, 18 and 19 March but nothing was recorded in relation to the content of discussions or whether the family raised concerns, and how these were responded to. The nursing care plan developed on Mrs A's arrival in the high dependency unit on 21 March 2013 noted the requirement to 'listen to relatives' needs and problems and act on information

[1] Royal College of Nursing: Perioperative fasting in adults and children - a good practice guideline

given as appropriate,' and information given to relatives should be recorded. Nursing Adviser 1 said these plans were entirely appropriate, but there was no evidence that they were acted upon. Furthermore, the standardised documentation included a section recording that visitors were being kept up-to-date, but these sections were left blank from 23 until 31 March 2013. As for the nursing notes, there was an entry on 26 March indicating that the family were involved in discussions about pain control, but nothing else was recorded about relatives' participation or information sharing between 23 March and 7 April 2013. Following a recorded discussion with the clinician about the DNACPR decision on 16 April 2013, there was nothing recorded in the notes about communication with the family in the following eight days.

24. Overall, Nursing Adviser 1 concluded that the standard of communication did not reflect a clinical team seeking to effectively involve relatives as partners in care. It also appeared that the quality and manner of the communication may have been lacking at times. In this regard, Nursing Adviser 1 pointed to the inaccurate falls report and the fact that the Board acknowledged in their response that the attitudes of some staff may have fallen below the standards expected of them (though it was not possible to tell from the medical records whether staff used inappropriate, judgemental terminology or tone).

25. Finally, in relation to the DNACPR decision, the Medical Adviser said that in line with the policy[2], the doctors completed the form to avoid what they thought would be a futile cardiopulmonary resuscitation in the event of Mrs A's cardiac arrest and that the decision was reasonable. However, there were shortcomings. Discussions with the family on this specific issue took place after the form was completed, but the Medical Adviser said it would have been better care if this had been done as soon as possible, and before completing the form. The form can be completed in advance of communicating with families; however, where the decision can be delayed, it is reasonable to wait and communicate with the family, as it could have been in this case. The form also had a timeframe for a review of the decision completed, but this was left blank contrary to the policy. Furthermore, the doctor completing the form included the information that Mrs A was housebound and partly based the DNACPR decision on this fact in addition to her severe health conditions. However, this assessment appeared to judge the quality of Mrs A's life, which was

[2] NHS Scotland: Do not attempt cardiopulmonary resuscitation - decision-making and communication

inappropriate and unreasonable; such decisions should always be based on a clinician's professional judgement that cardiopulmonary resuscitation would 'fail in achieving sustainable breathing and circulation' and that any assertive efforts would result in suffering and indignity. Having said that, the Medical Adviser said that these were shortcomings which could easily have been addressed and that there were instances of good practice. The Medical Adviser reiterated that the initial DNACPR decision itself was reasonable and following further communication with the family several days later, another doctor reversed the decision which was clearly documented in the medical records and communicated to staff, and the Medical Adviser considered this to be good care for Mrs A and an example of good communication with her family.

(b) Conclusion

26. Mrs C complained that the Board failed to provide a reasonable standard of care and treatment to Mrs A when she was a patient at the Royal Infirmary of Edinburgh. She was particularly concerned about the provision of nutrition and fluid in the lead up to the operation on 20 March 2013, communication with staff and the decision-making around the initial DNACPR decision. In reaching my decision, I have taken into account information Mrs C provided, Mrs A's medical records and the advice I have received. Turning first to the provision of nutrition and fluids, Nursing Adviser 2 said that this was unreasonable particularly given Mrs A's pain. I accept that advice. I am concerned about the Board's approach, which Nursing Adviser 2 described as 'antiquated practice'. Moreover, Nursing Adviser 1 said that communication was not of a reasonable standard. Related to this, the advice I have accepted is that there were shortcomings around the DNACPR decision including failure to involve the family in the decision-making process (although the decision itself was reasonable). I uphold the complaint. The recommendations concerning communication I made under complaint (a) will address the communication failures I found here, and I have made recommendations to address the other failures.

(b) Recommendations

27. I recommend that the Board:	*Completion date*
(i) review their practice in relation to the pre-operative provision of nutrition and fluid in light of Nursing Adviser 2's comments;	7 January 2015
(ii) ensure that clinical practice, decision-making	7 January 2015

	processes and clinical records in relation to DNACPR decisions are in line with the relevant policy;	
(iii)	ensure the failures identified are raised with relevant staff; and	7 January 2015
(iv)	apologise to Mrs C for the failures identified in this investigation.	7 January 2015

28. The Board have accepted the recommendations and will act on them accordingly. The Ombudsman asks that the Board notify him when the recommendations have been implemented.

Annex 1

Explanation of abbreviations used

Mrs A	the aggrieved
Mrs C	the complainant
the Board	Lothian NHS Board
Nursing Adviser 1	one of the Ombudsman's advisers who specialises in mental health
Nursing Adviser 2	one of the Ombudsman's advisers who specialises in nursing
the Medical Adviser	one of the Ombudsman's advisers who specialises in care of the elderly
DNACPR	Do not attempt cardiopulmonary resuscitation

Annex 2

Glossary of terms

distal femur	a bone immediately above the knee
hypertension	high blood pressure
osteoarthritis	a form of arthritis affecting the joints
pneumonia	inflammatory condition of the lung
severe aortic stenosis	narrowing of a valve in the heart